RHODE ISLAND MEDICAL ASSISTANCE PRIOR AUTHORIZATION REQUEST FORM

RECIP MID (SSN) _____ LAST NAME _____ FIRST NAME _____ MI ___ BIRTH DTE _____

REFERRING MEDICAID PROVIDER NUMBER _____ REFERRING MEDICAID PROVIDER NAME _____

REFERRING NON-MEDICAID PROVIDER NUMBER _____ REFERRING NON-MEDICAID PROVIDER NAME _____

ADDRESS _____ CITY _____ ST _____ ZIP _____ PHONE _____

DHS ONLY	LINE ITEM	PERFORMING PROV NUM	START DATE	END DATE	NDC/PROC/REV/MOD or NDC/PROC/REV/MOD RANGE	MOD	TTH MOD	TTH SRF	DIAG CODE or DIAG CODE RANGE	UNITS/ OCCUR	DOLLAR AMOUNT	POS	SVC CAT

STATEMENT OF MEDICAL NECESSITY _____
(reason service is required, diagnosis/prognosis _____
and treatment prescribed)

REFERRING PROVIDER SIGNATURE AND TITLE _____ REQUEST DATE _____

OFFICIAL USE DHS AUTHORIZED _____ DATE _____

DO NOT WRITE DHS DENIED _____ DATE _____

BELOW LINE NOTES _____

_____